TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Dallas Orthopedic and Shoulder Institute

Respondent Name
Vigilant Insurance Company

MFDR Tracking Number
M4-15-3353-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
June 9, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Chubb denied the office visit for date of service 12-11-2014. We requested reconsideration back in March 2015 … Please help us to get paid for the office visit…"

Amount in Dispute: $221.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "With regard to CPT code 99213, Respondent denied the request as the charge for the office visit is inclusive in the other procedure performed on the same day, CPT code 20610 per the CPT surgical package definition. Therefore, separate reimbursement is not owed for CPT code 99213."

Response Submitted by: Downs-Stanford, P.C.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 11, 2014	Evaluation & Management, established patient (99213)	$221.00	$114.44

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the guidelines for billing and reimbursing professional medical services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 236 – This proc or proc/mod combo not compatible
   - R09 – CCI; CPT Manual and CMS coding manual instructions

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the Maximum Allowable Reimbursement (MAR) for the disputed services?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code "236 – This proc or proc/mod combo not compatible," and "R09 – CCI; CPT Manual and CMS coding manual instructions." 28 Texas Administrative Code §134.203 (b) requires that "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

   Review of the submitted information finds that the service in dispute is CPT Code 99213 billed with modifier 25. The insurance carrier states in their position statement that this code is "inclusive in the other procedure performed on the same day, CPT code 20610." The Medicare Claims Processing Manual, Chapter 12, Section 40.1 C states, "Visits by the same physician on the same day as a minor surgery … are included in the payment for the procedure, unless a significant, separately identifiable service is also performed." In Section 40.2 A, 8, the Manual also indicates that modifier 25 is used to report a "significant, separately identifiable evaluation and management service … above and beyond the usual preoperative and postoperative care associated with the procedure or services that was performed.

   The narrative submitted with the dispute supports the use of modifier 25 in association with CPT Code 99213. The insurance carrier's denial reason is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

2. The Medicare fee is the sum of the geographically adjusted work, practice expense, and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. The Division conversion factor for 2014 is $55.75.

   For CPT Code 99213 on December 11, 2014, the relative value (RVU) for work of 0.97 multiplied by the geographic practice cost index (GPCI) for work of 1.014 is 0.983580. The practice expense (PE) RVU of 1.00 multiplied by the PE GPCI of 1.013 is 1.013. The malpractice RVU of 0.07 multiplied by the malpractice GPCI of 0.803 is 0.056210. The sum of 2.052790 is multiplied by the Division conversion factor of $55.75 for a MAR of $114.44.

3. The total MAR for the disputed service is $114.44. The insurance carrier paid $0.00. Therefore, an additional reimbursement of $114.44 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $114.44.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $114.44 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Laurie Garnes	July 15, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.